

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4108

Reg. Dist. No. **04102**

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook</u> c. LENGTH OF STAY IN 1b <u>23 yrs. 6 mos. 3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>David (Dave) Davis</u> First Middle Last | | 4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1910</u> 9. AGE (In years, last birthday) <u>50</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Hudson Davis</u> 14. MOTHER'S MAIDEN NAME <u>Louise King</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Wm. Hughes</u> Address <u>Seabrook MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Schizophrenic Reaction, Paranoid Type</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed at 630 AM</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had been a fall at Coronado US</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Seabrook Calvert MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input type="checkbox"/>. Inquiry <input type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>. | | | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) _____ | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4/14/61</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Home</u> 22b. DATE THEREOF <u>4/12/61</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese</u> ADDRESS <u>108 W. 1st St. of Cambridge</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u> 24a. REC'D BY REGISTRAR <u>APR 24 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1915

(M)

WILLIAM J. DUFFY
JANUARY 1, 1915

CHAS. J. DUFFY

CHAS. J. DUFFY

CHAS. J. DUFFY

CHAS. J. DUFFY

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CHAS. J. DUFFY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04103**

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|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY IN 1b <u>75 x -3</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co. Hospital</u> e. STREET ADDRESS <u>309 Nantuxet</u> f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburgh</u> d. STREET ADDRESS <u>309 Nantuxet</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert Thomas Lutz</u> First Middle Last 4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1961</u> | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 9, 1912</u> 9. AGE (In years last birthday) <u>48</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Finance Co</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u> 11. BIRTHPLACE (State or foreign country) <u>Pa</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Harry Lutz</u> 14. MOTHER'S MAIDEN NAME <u>Minnie Smith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or date of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>176-05-9263</u> 17. INFORMANT <u>Lutz</u> Address <u>309 Nantuxet St</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been out to dinner - came back & went to bed. Found</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>420-1</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>423 Am - heart damaged - infarction</u> 20c. TIME OF INJURY Month, Day, Year <u>1961</u> Hour <u>3</u> a. m. <u>3</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Friends home</u> 20f. (City or town) (County) (State) <u>Salmon Cabot Md</u> | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input "="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>. | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> EXAMINER'S NAME (Type) <u>H. W. WARD.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Ornig W</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried - Cabot</u> 22b. DATE THEREOF <u>Apr. 23, 1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann - Northampton</u> 22d. LOCATION (City, town, or county) (State) <u>Pittsburgh Pa.</u> | | 24a. REC'D BY REGISTRAR <u>APR 25 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Calvert</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co., Hospital</u> | | | | e. STREET ADDRESS <u>1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Frederick</u> Last <u>Myers</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1961</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 22 - 1909</u> | | 9. AGE (In years last birthday) <u>51</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing & Heating</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frederick Myers.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lena Schlote</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>219-07-8094</u> | | 17. INFORMANT <u>Daughter</u> Address <u>Kathleen Myers - Prince Frederick Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> al work <input type="checkbox"/> al work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1961</u> , to <u>April 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1961</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Page C. Jett</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4/7/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u> | | | | 22d. ADDRESS <u>PRINCE FREDERICK</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/7/61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Scwartz Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>PR 7 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u> | |

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REPUBLIC OF SOUTH AFRICA

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04105

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| 1. PLACE OF DEATH a. COUNTY CALVERT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CALVERT COUNTY HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MD b. COUNTY CALVERT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DARES BEACH (Rural) d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM LINDEN O'NEILL First Middle Last | | | | 4. DATE OF DEATH Month Day Year APR. 29 1961 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH OCT. 29, 1914 46 YRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR | | 10b. KIND OF BUSINESS OR INDUSTRY STATE ROADS | | 11. BIRTHPLACE (County & State, or foreign country) CALVERT CO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MARTIN O'NEILL | | | | 14. MOTHER'S MAIDEN NAME MAX TYDINGS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) MERCHANT MARINE 219-16-1321 | | | | 16. SOCIAL SECURITY NO. ELLOUISE O'NEILL - PRINCE FREDERICK, MD. | | | |
| 17. INFORMANT Address | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-8-1945 to 29 April, 1961 , that (I) (we) last saw the deceased alive on 29 April, 1961 , and that death occurred at p.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE G. J. Weems M.D. | | | | 22b. DATE SIGNED 5/1/61 | | | |
| 22c. PHYSICIAN'S NAME (Type) G. J. WEEMS | | | | 22d. ADDRESS Huntingtown, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF MAY 1, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEM. | | 23d. LOCATION (City, town or county) (State) PRINCE FREDERICK, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE G. A. Harkness & Son - MUTUAL, MD ADDRESS | | | | 25a. RECEIVED BY REGISTRAR MAY 3 61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04106

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|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Calvert MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Calvert | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co. Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS Olivett, Md. | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Phillips Last Phillips | | | | 4. DATE OF DEATH Month 4/ Day 5 Year 1961 | | | |
| 5. SEX F | | 6. COLOR OR RACE C | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/27/ 1903 | |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months 5 Days 27 | | IF UNDER 24 HRS. Hours 5 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. A | | | | | | | |
| 13. FATHER'S NAME Henry W. Kent | | | | 14. MOTHER'S MAIDEN NAME Mary Skinner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 213-16-4610 | | 17. INFORMANT Howard Kent Address Olivett, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Desolator DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-8 1961 , to 5 pm 1961 , that (I) (we) last saw the deceased alive on 5 pm 1961 , and that death occurred at 2 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) [Signature] | |
| 22d. ADDRESS | | | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 4/9/61 | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Eastern Chapel | | 23d. LOCATION (City, town, or county) (State) Calvert, Co., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Embury E. Sewell | | | | 24a. REC'D BY REGISTRAR DATE APR 11 '61 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |
| 24c. ADDRESS Prince Frederick | | | | | | | |

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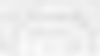
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04107

4113

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| 1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 4 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach | |
| 3. NAME OF DECEASED (Type or print) First MARGARET Middle MARY Last PRITCHARD | | 4. DATE OF DEATH Month April Day 13 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 3, 1875 |
| 9. AGE (In years last birthday) 85 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - retired | |
| 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY England | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. - - - | |
| 17. INFORMANT Calvert County Hospital records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral accident DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 31 Nov 19 61 , to 10 Apr 19 61 , that I last saw the deceased alive on 4-13- 19 61 , and that death occurred at 5 A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Huntingtown Maryland DATE SIGNED 4/4-61 | | | |
| ACTUAL SIGNATURE Dr. G. J. Weems | | M.D. | |
| PHYSICIAN'S NAME (Type) Dr. G. J. Weems | | Huntingtown Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 15, 61 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Suitland Road Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Futchers Funeral Home | | ADDRESS Quinns Rd. | |
| 24a. REC'D BY REGISTRAR APR 17 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04108

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wash</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u> | | c. LENGTH OF STAY IN 1b <u>2 da</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hosp.</u> | | d. STREET ADDRESS <u>Rocky Mt</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Richard Phillip Wheelers</u> | | 4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 26 '36</u> |
| 9. AGE (In years last birthday) <u>24</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Willie Holt Wheelers</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Nelson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Richard Wheelers</u> | | Address <u>5101 Earlswood Rd</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto hit tree</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> a. m. <u>4</u> 15 1961 | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hyper #2</u> | | 20f. (City or town) (County) (State) <u>St Leonard Calvert MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H. W. Ward</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Ownup</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>Ward</u> <u>4/17/61</u> | |
| EXAMINER'S NAME (Type) <u>H. W. WARD</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | |
| 22b. DATE THEREOF <u>Apr. 18, 1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pine View Cemetery</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Rocky Mount N.C.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Haskins & Son Mutual Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>APR 20 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04109**

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co. Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Republic d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William, Joseph Vernon | | 4. DATE OF DEATH Month 4 Day 18 Year 1961 | |
| 5. SEX M | 6. COLOR OF RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan 29, 1906 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Repairman, Corp. Etc. | | 10b. KIND OF BUSINESS OR INDUSTRY MD | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph S. Williams | | 14. MOTHER'S MAIDEN NAME Ethel Griffith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 214-12-9745 | |
| 17. INFORMANT Mr. Eugene Williams, Port Republic | | Address — | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) — | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Has had pain in chest for two days | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. — | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) — | |
| 20c. TIME OF INJURY Hour — a. m. — p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street Calvert MD | 20f. (City or town) Port Republic (County) MD (State) MD |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE H. W. Ward | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) H. W. Ward | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Apr. 21, 1961 | 22c. NAME OF CEMETERY OR CREMATORY Christ Church | 22d. LOCATION (City, town, or county) Port Republic (State) MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE G. G. Harkness | | 24a. REC'D BY REGISTRAR APR 20 1961 DATE | |
| ADDRESS for Mutual, MD | | 24b. REGISTRAR'S SIGNATURE Arthur A. Fraser | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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